State of California Department of Consumer Affairs

PHYSICIAN ASSISTANT COMMITTEE
MEDICAL BOARD OF CALIFORNIA
1424 Howe Avenue, Suite 35, Sacramento, CA 95825-3237
Telephone: (916) 263-2670 (800) 555-8038 FAX: (916) 263-2671
CALIFORNIA RELAY SERVICE BY TDD: 1-800-735-2929
E-mail: pacommittee@medbd.ca.gov
Website: www.physicianassistant.ca.gov

CHECK SHEET/GENERAL INFORMATION
To the Application for Physician Assistant Licensure

We want to process your application as soon as possible. You can help! Please use the following information checklist to be sure that your application is complete and accurate before submitting it. All items listed on the front and back that are applicable to you must be submitted in order for your qualifications for licensure to be assessed.

FORMS

- ☐ Form PA1-4 *Application for Physician Assistant Licensure*
- ☐ Form PA 5 *Certification of Completion of Physician Assistant Training Program* must be sent by you to your training program. The training program must complete the form and forward it *directly* to the PAC. Fax copies are **not** acceptable.
- ☐ Form PA6 *Verification of Licensure* must be submitted by you to every state in which you are/have been licensed or otherwise registered to practice as a physician assistant or other health care provider. Please make additional copies of this form as needed. Each licensing agency must then forward the completed form, with their agency seal, directly to the PAC. FAX copies are **not** acceptable.

PHOTOGRAPH

- ☐ One (1) recent 2" x 2" (approximate size) passport size photo of your head and shoulders only

REQUEST FOR RELEASE OF PANCE SCORES FROM THE NCCPA

- ☐ Contact the National Commission on Certification of Physician Assistants (NCCPA,12000 Findley Road, Suite 200, Duluth, GA 30097 telephone: (678) 417-8100) to authorize release of your Physician Assistant National Certifying Examination (PANCE) scores. Your PANCE scores must be sent by the NCCPA directly to the PAC. FAX copies are not acceptable.

FINGERPRINT PROCEDURES

Before the Physician Assistant Committee issues a license, clearances must be received from the Department of Justice (DOJ) and Federal Bureau of Investigation (FBI) to document that the applicant has no criminal history. Two methods are available to complete the fingerprint requirement:

1. Live Scan Process.

For applicants residing in or near California we recommend that you use this process. On average, Live Scan results are received within 1 – 2 weeks.

Live Scan Procedures

1. Complete the PAC's "Request for Live Scan Services" form in triplicate.
2. Take the completed form (in triplicate) to a Live Scan location.
3. Pay the processing and rolling fees to the Live Scan site.
4. Submit the **second copy** of the form with your physician assistant license application and a $25 check or money order payable to the Physician Assistant Committee to cover application processing.

The PAC will be unable to process your application without the second copy of the "Request for Live Scan Services" form.

Visit www.caag.state.ca.us/fingerprints/publications/contact.pdf to locate a Live Scan location. Hours of operation and fees vary, so please contact the Live Scan site directly for information.

2. Fingerprint Cards.

If you reside outside of California or are unable to obtain Live Scan services you may use the manual fingerprint card process. Please contact the PAC to obtain fingerprint cards. Results from the manual card process are usually received within 4 – 6 weeks.

Manual Fingerprint Card Process.

1. Contact the PAC to obtain two fingerprint cards.
2. Complete all areas marked by a red "x" on both cards.
3. Take the completed cards to a local law enforcement office and have your fingerprints rolled.
4. Submit both fingerprint cards with your physician assistant license application and a $91 check or money order payable to the Physician Assistant Committee to cover application processing. DO NOT FOLD CARDS.

The PAC will be unable to process your application without both completed fingerprint cards.

Your physician assistant license will not be issued until the committee receives fingerprint clearance from both the Department of Justice and the Federal Bureau of Investigation.

🗁 **FEES**

❒ Application Processing Fees (nonrefundable)

- With Live Scan fingerprinting = $25
- With Manual Fingerprint cards = $91
- Make check or money order payable to the Physician Assistant Committee.

☐Notary – Application must be notarized.

Interim Approval

The PAC may grant interim approval to practice as a PA in those circumstances where the applicant has completed an approved PA training program and has applied to take the PANCE following graduation.

If you wish to be considered for interim approval, please see Question 10 of the application.

The initial request for interim approval must be signed by you and list the name(s) of your supervisors. Changes of supervisor(s) must be faxed or mailed to the PAC. Changes of supervision must include your signature and date. ***You may not begin practicing with a requested supervisor(s) until you receive written authorization from the PAC.***

The review and approval process may take approximately four (4) weeks provided we receive all required documentation. Please do not contact the PAC regarding the status of your approval for at least 4 weeks after submitting your application.

Reasons for not granting Interim Approval

✦Applicant is a licensed PA in another state
✦Previously took the PANCE
✦Supervisor name(s) not submitted

General Information

APPLICATION PROCESSING TIMES Your application is considered complete once all required forms, documentation, FBI and DOJ criminal record clearance, and appropriate fees have been received and approved. You will be notified of the status of your application, including any file deficiencies, generally within 30 days from the date your application is received. We recognize that some items may be in transit; however; in an effort to ensure that your application can be reviewed in a timely manner, ***we ask for your patience in not calling for the status of your application until after this 30-day period*.**

ADDRESS OF RECORD It is your responsibility to provide, in writing, notice of any address or name changes to the Physician Assistant Committee. All correspondence will be sent to your address or record.

APPLICATION DENIAL If your application is denied by the Physician Assistant Committee you will be notified in writing the reason(s) for denial and the appeal process.

ABANDONMENT OF LICENSURE APPLICATION Title 16, Division 13.8, Section 1399.512(d) states, "An applicant shall be deemed to have abandoned his or her licensure application if the application is not completed or if requested documents or information are not provided or if required fees are not paid, within one year from the date of filing or written request by the committee. An application submitted subsequent to an abandoned application shall be treated as a new application."

PRACTICING AS A PA You may **not** begin practicing as a PA in California until:

1. You have been granted either Interim Approval or license by the PAC; and,
2. Have a supervising physician with whom you have established in writing:
   - Transport and back-up procedures for patients; and,
   - A Delegation of Services Agreement that includes guidelines for adequate supervision of the PA. A sample copy of this document is available on the committee's website: www.physicianassistant.ca.gov.

CONTINUING MEDICAL EDUCATION California does not currently require Continuing Medical Education for renewal of a physician assistant license.

PHYSICIAN ASSISTANT LAWS AND REGULATIONS It is the applicant's responsibility to know and to keep current on the laws and regulations pertaining to the practice as a physician assistant as they are subject to change. You may obtain a copy of the physician assistant laws and regulations at the PAC website: www.physicianassistant.ca.gov.

NOTICE OF COLLECTION OF PERSONAL INFORMATION All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensure per Section 3519 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental or law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Executive Officer is the custodian of records.

State of California Department of Consumer Affairs

PHYSICIAN ASSISTANT COMMITTEE

Medical Board of California
1424 Howe Avenue, Suite 35
Sacramento, CA 95825-3237
1-800-555-8038 (916) 263-2670 Fax (916) 263-2671
E-mail: pacommittee@medbdca.gov
Website: www.physicianassistant.ca.gov

APPLICATION FOR LICENSURE PHYSICIAN ASSISTANT

Please READ all instructions prior to completing this application. ALL questions on this application must be answered, and all supporting documents must be submitted with this application as per instructions. Please type or print neatly. When space provided is insufficient, attach additional sheets of paper.

Application fee for licensure (Non-Refundable). Select one option only, application fee using:
☐ LiveScan $ 25.00 ☐ Fingerprint cards $ 91.00

PAC USE ONLY ☐

PART I: TO BE COMPLETED BY APPLICANT

1. Name: Last First Middle

Personal Data ☐

2. Other names you have used (include birth name)

3. Social Security Number ☐

4a. Public Address; will be released by the Committee to the public. This address will also be used for all correspondence throughout the application process.

5. Sex: ☐ Female ☐ Male ☐

_____
Number and Street/Rural Route (include apartment number, if applicable)

_____
City State Zip Code Country ☐

4b. Confidential Address; Applicants must provide a confidential street address if a P.O. Box is used as the Public Address in Question #4a.

_____
Number and Street/Rural Route (include apartment number, if applicable)

_____
City State Zip Code Country

E-mail Address (Optional - for office use only): _____

6. Date of Birth: Mo/Day/Year

7. Telephone:
Home ( ) Message ( ) ☐

8. Physician Assistant Program Attended:

Education ☐

Name of PA Training Program	Address	Telephone Number

School Code _____

γ MANDATORY DISCLOSURE OF SOCIAL SECURITY NUMBERS

Disclosure of your social security number (or federal employer identification number (FEIN), if you are a partnership) is mandatory. Section 30 of the business and professions code and public law 94-455 (42 USCA 405 (c) (2)(C) authorize collection of your social security number. Your social security number will be used exclusively for tax enforcement purposed, for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of license or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number FEIN, your application for initial licensure will not be process AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

PA1

9a. Have you ever applied for a California physician assistant license? ☐ Yes ☐ No

9b. Are you, or have you ever been, licensed or otherwise registered in any manner in any state or country in any healthcare occupation?

(If YES, please complete Form PA6. See Instruction page.) ☐ Yes ☐ No

If YES, list type of license, state, license number, issue date, expiration date and current status. (Use a separate sheet if necessary.)

Type of License	State or Country	License Number	Date of Licensure From:	To:	Current status of License (active, inactive, suspended, revoked, other, explain)

INTERIM APPROVAL

Interim Approval

10. Are you requesting Interim Approval? ☐ Yes ☐ No

Written Exam

11. Have you ever taken the Physician Assistant National Certifying Examination (PANCE) as administered by the National Commission on Certification of Physician Assistants (NCCPA) ..... ☐ Yes ☐ No

Examination Date: _____ Month _____ Year

If you answered Ayes@ to Question 11, you are not eligible for Interim Approval. Please proceed to Question 13.

12. Indicate the month and year of the PANCE examination that you have applied to take:

_____ Month _____ Year

List the name(s) of your supervising physician(s) and include each supervising physician's medical license number. (If you need more space, please continue on a separate sheet.) Interim Approval will be issued only if you submit the name(s) of your supervising physician(s). If you do not have a supervising physician, you can request Interim Approval at a later date. *Interim approval cannot be granted until supervising physician name(s) is/are provided to the PAC.*

Supervisor Name: _____ California Medical License Number: _____

Supervisor Name: _____ California Medical License Number: _____

STATEMENT OF UNDERSTANDING

I understand that Interim Approval shall be valid for the time specified on the actual certificate and is not renewable. If I should fail the PANCE examination I shall cease practicing as a physician assistant and I shall return the original interim approval certificate to the Physician Assistant Committee. _____ (Applicant's Initials)

A...If the applicant fails the examination, the interim approval automatically terminates upon the applicant=s receipt of notice of such failure from the committee or by the National Commission on Certification of Physician Assistants.@ (Ref: Section 1399.508(a), Physician Assistant Regulations)

_____ (Applicant's Initials)

QUESTIONS 13 - 18: For any positive response to the following questions, please provide ALL official documentation regarding the matter in addition to written explanations. If applicable, an applicant should also provide official hearing/court documents and original letters of explanation from training program directors or other appropriate authorities. APPLICANTS ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

License Data

13. Have you ever had a healing arts license or certificate denied or disciplined by this state or any other state or have you ever surrendered such a license or certificate? ..... ☐ Yes ☐ No

(If YES, give details (locations, dates, rulings). Use a separate sheet if necessary.

PA2

14. Have you ever withdrawn from, or been suspended, dismissed or expelled from a physician assistant training program or have you ever taken a leave of absence from such a program? If YES, please attach a written explanation. …… ☐ Yes ☐ No ☐

15. Have you ever been charged with, or been found to have committed, unprofessional conduct, professional incompetence, gross negligence or repeated negligent acts or malpractice by any licensing board, other agency, or hospital or has any disciplinary action ever been filed or taken regarding any healing arts license which you now hold or have ever held, or is any such actions pending? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. governmental agency. If YES, give details below ..... ☐ Yes ☐ No ☐

State	Date	Charge	Disposition	

16. Have you ever been denied a license, permission to practice medicine or any other healing art, or denied permission to take an examination in any state, country, or U.S. federal jurisdiction, or is any such action pending? ..... ☐ Yes ☐ No ☐
If YES, give details below.

State	Date of Denial	Reason for denial	

17. Have you ever voluntarily surrendered a license to practice in the healing arts in this or any other state, or voluntarily surrendered your narcotic (controlled substance) permit (state or federal) to any licensing board or any other agency, or is any such action pending? ..... ☐ Yes ☐ No ☐

18. Do you have any condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety, including but not limited to, any of the following? ..... ☐ Yes ☐ No ☐

If Yes, please check the appropriate box(es) below:

- ☐ A condition which required admission to an inpatient psychiatric facility.
- ☐ Alcohol or chemical substance dependency or addiction
- ☐ Emotional, mental or behavioral disorder.
- ☐ Other (explain): _____

For any of the boxes checked above, please submit complete <u>official</u> inpatient and outpatient treatment records, evidence of ongoing rehabilitation treatment, and a personal written explanation

19. For any positive response to the following questions, please provide all official arrest (including police reports) and hearing/court documents. You are required to include any conviction that has been set aside and dismissed or expunged, or where a stay of execution has been issued.

19a. Have you ever been convicted of or pled nolo contendere to any violation (including misdemeanor or felony) of any local, state, or federal law of any state, territory, country, or U.S. federal jurisdiction? ☐ Yes ☐ No ☐

19b. Is any criminal action related to the above pending? ☐ Yes ☐ No

You are required to list any conviction that has been <u>set aside and dismissed or expunged, or where a stay of execution has been issued</u>.

Violation and Location	Date	Penalty or disposition	

PA3

TOP OF PHOTO

INSTRUCTIONS: Photographs, must be of head and shoulders only.

Attach a 2@ x 2" (approximate size) photograph in this space.

No Polaroid or scanned photos allowed.

BOTTOM OF PHOTO

STATE OF_____ **COUNTY OF** _____

The applicant, _____ **, being first duly sworn upon his/her**

oath deposes and says: that I am the person herein named subscribing to this application: that I have read the complete application and know the full content thereof, and declares that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the Physician Assistant Licenses as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which the applicant is aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present, and future), business and professional associates (past, present, and future), and all government agencies (local, state, federal or foreign) to release to the Physician Assistant Committee or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by the Committee in connection with this application; or any further or future investigation by the Committee necessary to determine my medical competence, professional conduct or physical or mental ability to safely engage in the practice of medicine. I further authorize the Physician Assistant Committee or list successors to release to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure. **I FURTHER ACKNOWLEDGE THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION IS ADEQUATE TO DENY THE SAME OR TO HOLD A HEARING TO REVOKE THE SAME, IF ISSUED.**

SIGNATURE OF APPLICANT: _____

(PLEASE WRITE FULL NAME, NOT INITIALS)

Signed and sworn to before me this _____ Day of _____

Signature of Notary Public: _____ Address: _____

_____

My commission expires: _____

PA 4

NOTICE OF COLLECTION OF PERSONAL INFORMATION All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensure per Section 3519 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental or law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Executive Officer is the custodian of records.

State of California Department of Consumer Affairs

PHYSICIAN ASSISTANT COMMITTEE
MEDICAL BOARD OF CALIFORNIA
1424 Howe Avenue, Suite 35, Sacramento, CA 95825-3237
Telephone: (916) 263-2670 (800) 555-8038 FAX: (916) 263-2671
CALIFORNIA RELAY SERVICE BY TDD: 1-800-735-2929
E-mail: pacommittee@medbd.ca.gov

CERTIFICATION OF COMPLETION OF PHYSICIAN ASSISTANT TRAINING PROGRAM

Print or Type *(Read instructions before completing)*

(A) TO BE COMPLETED BY APPLICANT:

1. NAME:	LAST	FIRST	MIDDLE

2. MAILING ADDRESS:	NUMBER & STREET	CITY	STATE	ZIPCODE

3. TELEPHONE:

(B) TO BE COMPLETED BY PROGRAM:

This certifies that _____ of _____, matriculated
NAME *ADDRESS*

in _____ and has attended this institution
NAME OF PA PROGRAM

from _____, _____, TO _____, _____, completing the training
MONTH / DAY *YEAR* *MONTH / DAY* *YEAR*

for certification as a Physician Assistant as set forth in the Physician Assistant regulations and that he/she

graduated and was granted a _____ on the _____day
SPECIFY WHETHER DEGREE OR DIPLOMA

of _____, _____.
MONTH *YEAR*

Signed and the school seal affixed this

_____ *day of* _____, _____

OFFICIAL SEAL

By _____

Title_____

PA 5

After completion by the approved Program this form must be forwarded by the Program to the Committee at the above address

State of California Department of Consumer Affairs

PHYSICIAN ASSISTANT COMMITTEE
MEDICAL BOARD OF CALIFORNIA
1424 Howe Avenue, Suite 35, Sacramento, CA 95825-3237
Telephone: (916) 263-2670 (800) 555-8038 FAX: (916) 263-2671
CALIFORNIA RELAY SERVICE BY TDD: 1-800-735-2929
E-mail: pacommittee@medbd.ca.gov

TO: State Medical Licensing, Registration, or Certification

_____
STATE BOARD NAME

_____
ADDRESS

_____

RE: Verification of License / Registration as a physician assistant or other health care profession.

I am applying for a license to practice as a physician assistant in the State of California and a verification of my licensure/registration/certification status by your agency is required. I hereby authorize your agency to release information concerning my licensure/registration or certification status. Please return this completed form to the PAC at the address listed above. All questions must be answered.

_____ _____
APPLICANT (PRINT OR TYPE) **BIRTHDATE**

_____
SIGNATURE OF APPLICANT

This is to certify that _____ was issued license / registration number_____ on _____ as a _____.

1. Date license, registration or certification issued _____ Date of Expiration _____
2. Have any complaints been filed against the license? _____YES _____NO ____UTA*
3. Is there any pending investigation regarding the license? _____YES _____NO ____UTA
4. Has any disciplinary activity been taken regarding this license? _____YES _____NO ____UTA

*unable to answer

If yes to any of the above, please provide any information and documentation which may be released; including charges and final disposition.

Verified by_____
SIGNATURE
Print Name _____
SEAL
Title_____
Date _____
Telephone Number _____

PA6

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0433 (Code assigned by DOJ) Type of Application: (check one) ☐ Employment ☒ License, Certification, Permit ☐ Volunteer

Job Title or Type of License, Certification or Permit: PHYSICIAN ASSISTANT

Agency Address Set Contributing Agency:

PHYSICIAN ASSISTANT COMMITTEE
Agency authorized to receive criminal history information

06339
Mail Code (five-digit code assigned by DOJ)

1424 HOWE AVENUE, STE. 35
Street No. Street or PO Box

RONI HOSS
Contact Name (Mandatory for all school submissions)

Sacramento CA 95825-3237
City State Zip Code

(916) 263-2670 X201
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First MI

AKA's: _____
Last First

CDL No. _____

DOB: _____ SEX: ☐ Male ☐ Female

Misc. No. **BIL -** APPLICANT MUST PAY (N/A)
Agency Billing Number (if applicable)

HT: _____ WT: _____

Misc. No. _____

EYE Color: _____ HAIR Color: _____

Home Address: (Applies only if Youth Org/HRA or Public Utility submission)

POB: _____

Street or PO Box

SOC: _____

City, State and Zip Code

Your Number: _____
OCA No. (Agency Identifying No.)

Level of Service DOJ ☒ FBI ☒

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

THIS SECTION IS NOT APPLICABLE
Employer Name

Street No. Street or PO Box

Mail Code (five digit code assigned by DOJ)

City State Zip Code

( ) Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed

BCII 8016 (Rev10/98) **ORIGINAL-Live Scan Operator; SECOND COPY-Requesting Agency; THIRD COPY-Applicant**

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0433 (Code assigned by DOJ) Type of Application: (check one) ☐ Employment ☒ License, Certification, Permit ☐ Volunteer

Job Title or Type of License, Certification or Permit: PHYSICIAN ASSISTANT

Agency Address Set Contributing Agency:

PHYSICIAN ASSISTANT COMMITTEE
Agency authorized to receive criminal history information

06339
Mail Code (five-digit code assigned by DOJ)

1424 HOWE AVENUE, STE. 35
Street No. Street or PO Box

RONI HOSS
Contact Name (Mandatory for all school submissions)

Sacramento CA 95825-3237
City State Zip Code

(916) 263-2670 X201
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First MI

AKA's: _____
Last First

CDL No. _____

DOB: _____ SEX: ☐ Male ☐ Female

Misc. No. **BIL -** APPLICANT MUST PAY (N/A)
Agency Billing Number (if applicable)

HT: _____ WT: _____

Misc. No. _____

EYE Color: _____ HAIR Color: _____

Home Address: (Applies only if Youth Org/HRA or Public Utility submission)

POB: _____

Street or PO Box

SOC: _____

City, State and Zip Code

Your Number: _____
OCA No. (Agency Identifying No.)

If resubmission, list Original ATI No. _____

Level of Service DOJ ☒ FBI ☒

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

THIS SECTION IS NOT APPLICABLE
Employer Name

Street No. Street or PO Box

Mail Code (five digit code assigned by DOJ)

City State Zip Code

( ) Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____
Name of Operator

Date _____

Transmitting Agency

ATI No.

Amount Collected/Billed

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0433 (Code assigned by DOJ) Type of Application: (check one) ☐ Employment ☒ License, Certification, Permit ☐ Volunteer

Job Title or Type of License, Certification or Permit: PHYSICIAN ASSISTANT

Agency Address Set Contributing Agency:

PHYSICIAN ASSISTANT COMMITTEE
Agency authorized to receive criminal history information

06339
Mail Code (five-digit code assigned by DOJ)

1424 HOWE AVENUE, STE. 35
Street No. Street or PO Box

RONI HOSS
Contact Name (Mandatory for all school submissions)

Sacramento CA 95825-3237
City State Zip Code

(916) 263-2670 X201
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First MI

AKA's: _____
Last First

CDL No. _____

DOB: _____ SEX: ☐ Male ☐ Female

Misc. No. **BIL -** APPLICANT MUST PAY (N/A)
Agency Billing Number (if applicable)

HT: _____ WT: _____

Misc. No. _____

EYE Color: _____ HAIR Color: _____

Home Address: (Applies only if Youth Org/HRA or Public Utility submission)

POB: _____

Street or PO Box

SOC: _____

City, State and Zip Code

Your Number: _____
OCA No. (Agency Identifying No.)

If resubmission, list Original ATI No. _____

Level of Service DOJ ☒ FBI ☒

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

THIS SECTION IS NOT APPLICABLE
Employer Name

Street No. Street or PO Box

Mail Code (five digit code assigned by DOJ)

City State Zip Code

( ) Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____
Name of Operator

Date _____

Transmitting Agency

ATI No.

Amount Collected/Billed